State Action on Pharmacy Benefit Management Carve Outs

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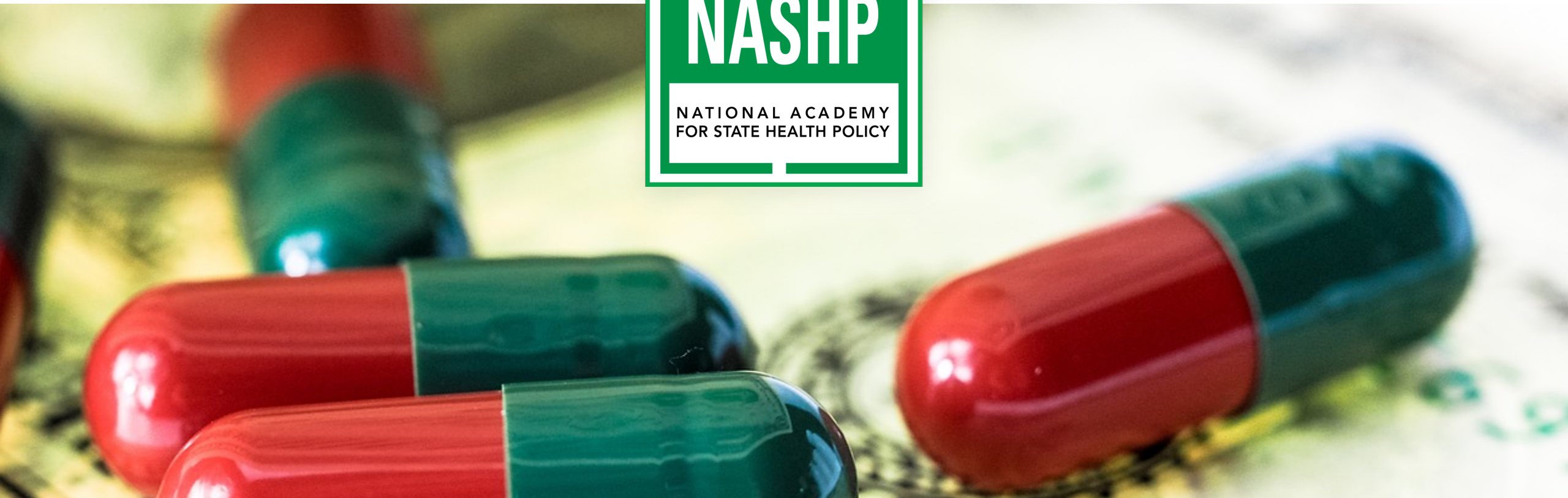

NASHP Center for Drug Pricing

NASHP launched the Center for Drug Pricing in 2016 to help states solve the problem of high prescription drug prices.

- The reality of state budgets – which need to remain in balance – creates an urgency to act

We accomplish our mission in multiple ways, including:

- Advancing innovation by supporting states in the development of new models
- Surfacing best practices by engaging states to inform data-driven policy
- Ensuring states have the data and tool to successfully design and implement policy
- Encouraging sustainable cross-sector solutions by strengthening partnership

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Setting the Stage: Enacted State Legislation

Since 2017, legislation to address prescription drug costs has been **introduced** in all 50 states & 49 states have **enacted** over 200 laws to address prescription drug costs

<u>Major categories of enacted legislation include:</u>

- PBM regulations (46 states)
- Drug price transparency (18 states)
- Out-of-pocket insulin caps (18 states)
- Wholesale importation from Canada (6 states)
- Prescription drug affordability boards (5 states)

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Setting the Stage: State Legislative Action

During the 2021 legislative session, states introduced new bills based on NASHP models to directly address manufacturers' list prices:

- Establishing international reference rates (bills in 7 states)

- Penalizing drug manufacturers for price increases unsupported by new clinical evidence (bills in 3 states)

States also continued to introduce bills to create drug affordability boards (11 states) & state importation programs (20 states)

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What is a pharmacy benefit carve out?

A carve out can provide more visibility into prescription drug costs, centralize and leverage negotiating power, and provide a single drug formulary with standard utilization management protocols

When a state carves out the pharmacy benefit from Medicaid managed care, the state directly reimburses pharmacy claims under a fee-for-service model

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West Virginia

- West Virginia carved out the prescription drug from its managed care contracts in 2017
- The Medicaid program now acts as its own PBM under a fee-for-service model
- To accomplish the carve-out, West Virginia:
  - Added an additional pharmacist to its staff
  - Stress-tested its existing claims processing system
  - Increased its capacity for prior authorizations
  - Educated the public and its help desk staff about the program change
- Carve out led to a savings of $54.5 million in 2018

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Ohio

- A 2018 report found the PBMS retained $224 million in profit in “spread” - the difference between what a PBM pays a pharmacy versus what it claims from Medicaid for a prescription
- Ohio first mandated managed care plans switch to contracts with transparent, pass-through payment models with PBMs
  - PBMs were reimbursed more directly through fees rather than spread
- In 2020, the state required all managed care plans to contract with a single PBM selected by the Medicaid department
  - SPBM works in coordination with a Pharmacy Pricing and Audit Consultant, which provides reimbursement design and oversight/auditing
  - Gives the state more authority over drug purchasing and reimbursement
  - Increases flexibility for beneficiaries, who no longer have to consider pharmacy benefits when selecting a managed care plan

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New York and California

- Both New York and California plan to carve out the pharmacy benefit from Medicaid managed care
  - Governor Newsom directed California's carve out via executive order
  - In New York, the carve out was the result of legislative action
- Both states have faced pushback from 340B entities who say they rely on revenue stream from drug reimbursement from Medicaid managed care plans and have delayed the implementation of their carve outs
  - Both states have delayed their carve outs due to concerns from 340B entities

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Washington

- Washington has not carved out the benefit or moved to a single PBM but it has created a single Preferred Drug List (PDL) for its Medicaid program
  - PDLs indicate which drugs are preferred and do not require prior authorization
  - Reduced the number of PDLs from six to one
- Advantages of a single PDL
  - Administrative ease for providers, patients, and pharmacies
  - Rebate maximization by selecting drugs with the lowest cost or maximum rebate potential
  - Rebate transparency for more accurate cost management
  - Fewer disruptions for patients who may switch between managed care plans

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Questions?

If you have questions or need more information contact Drew Gattine at dgattine@nashp.org

NASHP has recently released a new brief: State Strategies To Lower Drug Prices: New Legislative and Medicaid Models with a companion toolkit for legislators and other state policy makers look for solutions to the rising cost of prescription drugs

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